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**BEFORE THE ARIZONA REGULATORY BOARD
OF PHYSICIAN ASSISTANTS**

In the Matter of

CYNTHIA D. LAWRENCE, P.A.

Holder of License No. **2655**
For Performing Healthcare Tasks In the State of
Arizona.

Board Case Nos. PA-10-0035A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Letter of Reprimand with
Probation)

The Arizona Regulatory Board of Physician Assistants ("Board") considered this matter at its public meeting on November 17, 2010. Cynthia D. Lawrence, P.A. ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-2551(G). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. On April 26, 2010, Arizona Regulatory Board of Physician Assistants received copies of termination letters sent to Respondent by her supervising physician, Dr. Zehri, who also sent a letter which listed reasons for the termination and provided four patient names for chart review.
2. Patient AB is a 27-year-old female with a past medical history of chronic back pain, anxiety and depression, who established care with another physician at Desert Oasis Medical Center in July of 2009. Paxil, Alprazolam and Vicodin were prescribed, and films showed mild disk space narrowing and MRI was ordered.
3. AB first saw Respondent on January 12, 2010, and reported chronic back pain and a lack of emotional control. Respondent prescribed Hydrocodone/APAP #84, along with Alprazolam BID #60, and Seroquel, and referred AB to Mohave Mental Health. In February she also

- 1 prescribed Temazepam 15mg 1 p.o.q HS, but did not note the new prescription in AB's
2 chart.
- 3 4. In February Respondent referred AB for physical therapy and pain management and
4 prescribed Alprazolam .25mg TID #90, Clonazepam 1mg BID #60, and Temazepam 30mg
5 q HS at dinnertime. AB was subsequently seen by another P.A.
- 6 5. Patient BG is a 27-year-old male with a past medical history significant for chronic back pain
7 and smoking who established care with another provider at DOMC, Desert Oasis Medical
8 Center, on May 6, 2009. Small amounts of Flexeril and Vicodin were prescribed, and BG
9 was referred for pain management. The prescription amounts were increased in a follow-up
10 and early refills were subsequently provided.
- 11 6. On August 14, 2009, Respondent saw BG, who reported taking two to three Vicodin at a
12 time. She did not document a back exam or neurologic exam. Respondent prescribed
13 blood pressure medication along with #56 Vicodin and TID Flexeril. On August 25th she
14 provided further Vicodin to BG and authorized further refill requests on September 11th and
15 September 21st. At an October 13th appointment, Respondent wrote prescriptions for
16 Temazepam 15mg q HS #30, Alprazolam .25mg q HS #12, and Oxycodone/APAP #56. BG
17 subsequently reported GI upset and requested Hydrocodone/APAP which was approved for
18 refill on October 16th. Respondent approved a refill request for further Hydrocodone/APAP
19 six days later on October 22nd.
- 20 7. Respondent saw BG on November 2nd and prescribed Alprazolam .25mg BID #60,
21 Oxycodone/APAP q 4 to 6 hours for breakthrough #30, and Hydrocodone/APAP one q 4 to
22 6 hours #56. BG returned on November 11th and received further Hydrocodone.
23 Respondent saw him again on November 23rd and wrote prescriptions for
24 Oxycodone/APAP #84, Hydrocodone/APAP #56, Alprazolam .25mg q 12 hours #60.
- 25 8. Documentation on December 1, 2009, reported that BG had been a no-show for three visits

- 1 with pain management and a note was added to the front of BG's chart stating no more pain
2 medication 12/1/09. On December 23rd P.A. Lawrence saw BG and prescribed #84
3 Hydrocodone/APAP and #14 Oxycodone/APAP. She provided further prescriptions for
4 Oxycodone and Hydrocodone at subsequent appointments.
- 5 9. Patient CC is a 60-year-old female patient followed by Dr. Zehri at DOMC. Dr. Zehri
6 authorized refill requests for Diovan and Metformin and three refills were issued on
7 December 8, 2009. On December 11th DOMC received a new prescription request from
8 Express Scripts for Diovan 80mg. Respondent completed the Sig as "one p.o.q d," and
9 signed the prescription but did not include a medication quantity or refill number.
- 10 10. Patient AM is a 23-year-old female who established care with Respondent at Desert Oasis
11 Medical Center on September 25, 2009. Her past medical history was significant for prior IV
12 drug use, resultant strokes, multiple blood clots, pulmonary valve replacement, and a
13 current feeding tube. Medications were not documented. AM was noted to have cellulitis to
14 the PEG site and was on anticoagulation related to valve replacement. Ciprofloxacin BID times
15 10 days and Bactrim double-strength BID times 30 days were prescribed, along with
16 Coumadin 5mg and 2mg p.o. daily. Chantix and Megace were also prescribed, and
17 Methadone 10mg #2 p.o. QID #210 was prescribed for pain.
- 18 11. There was no documentation that AM was informed about the possible interactions between
19 Coumadin and the prescribed antibiotics. AM's INR was 1.2.
- 20 12. AM was next seen November 10th, and there were no intervening PT/INR values. She was
21 off Coumadin for PEG tube removal. Antibiotics were prescribed for otitis and a prescription
22 provided for Methadone 10mg 1 p.o. QID #10. The pharmacy subsequently authorized
23 #120 Methadone. On November 17th a notation was written on the front cover of AM's
24 chart which stated "no more pain meds," which appeared to have been signed by Dr. Zehri.
25 Respondent wrote a prescription for Methadone 10mg 2 p.o. QID #120 for AM on

- 1 December 1, 2009 and at the December 16, 2009, appointment, Klonopin #60 was
2 prescribed. AM was seen again December 23rd and reported insomnia due to pain.
3 Methadone 10mg 2 p.o. q 4 hours #120 was prescribed along with Flexeril, Temazepam at
4 dinnertime #30, and another 60 tablets of Klonopin 0.5mg BID. AM was subsequently seen
5 by Dr. Zehri who reduced her Methadone dose and facilitated a pain management.
- 6 13. During her Formal Interview, Respondent testified that her supervising physician gave her
7 no guidance and failed to provide a pain contract form for her to use. She stated that she
8 used a form from another practice. Respondent also claimed that she had no Internet
9 access and thus could not consult the pharmacy database to check on other prescriptions
10 her patients were obtaining. She admitted that she prescribed controlled substances for
11 more than the 14 day period for which she was authorized to write, but claimed that she did
12 her best to calculate how many pills would be needed over a 14 day period.
- 13 14. The standard of care requires a PA to avoid prescribing multiple benzodiazepine agents to
14 the same patient at the same time as there is no medical indication to do so.
- 15 15. Respondent deviated from the standard of care by providing multiple benzodiazepine
16 medications to the same patient (AB, BG, and AM) at the same time.
- 17 16. The standard of care requires a PA to avoid prescribing a benzodiazepine hypnotic agent
18 for long term treatment of insomnia as the medication is indicated for short term treatment.
- 19 17. Respondent deviated from the standard of care by prescribing Temazepam for insomnia as
20 a thirty-day prescription.
- 21 18. The standard of care when a patient fails to obtain labs, self-adjusts medications,
22 repeatedly requests early refills of narcotics, and misses multiple appointments with a pain
23 management provider requires a PA to suspect and address medication misuse and abuse
24 with the patient.
- 25 19. Respondent deviated from the standard of care by providing early refills of

- 1 Hydrocodone/APAP without addressing medication self-adjustment and lack of compliance
2 with testing and recommended pain management referral with BG.
- 3 20. The standard of care requires a PA to avoid prescribing two different short acting
4 narcotic/Tylenol combination medications to treat chronic pain as there is no medical
5 indication to do so.
- 6 21. Respondent deviated from the standard of care by providing two short-acting combination
7 narcotic/Tylenol agents at the same time to treat chronic pain.
- 8 22. The standard of care when a pharmacy prescription service requests clarification of a
9 prescription to include the quantity to be dispensed and the number of refills requires the
10 provider who authorized the prescription without specifying a quantity or refill to provide the
11 requested information.
- 12 23. Respondent deviated from the standard of care by failing to provide the requested
13 clarification of a prescription for Diovan that she had previously written.
- 14 24. The standard of care requires a PA to verify current medication use and dosage prior to
15 prescribing large doses of Methadone.
- 16 25. Respondent deviated from the standard of care by failing to verify AM's medication use prior
17 to providing a prescription for high-dose Methadone.
- 18 26. The standard of care when Ciprofloxacin is used in a patient taking Coumadin requires a PA to
19 inform the patient of the possible interaction and to instruct to monitor for bleeding and
20 bruising.
- 21 27. Respondent deviated from the standard of care by prescribing Ciprofloxacin to AM while
22 taking Coumadin without discussing the potential risks involved and need for increased
23 monitoring.
- 24 28. There was potential for misuse and abuse of the narcotic and benzodiazepine medications.
25 There was also increased potential for anxiolytic addiction and benzodiazepine overdose.

1 There was a potential for CC to experience a delay in receiving her prescription. In the case
2 of patient AM, there was potential for narcotic abuse, diversion, and overdose with
3 Methadone. There was also potential for anxiolytic abuse, addiction and overdose. There
4 was potential for increased bleeding in a patient on Coumadin for whom antibiotics were
5 prescribed that are known to increase the effects of Warfarin (Coumadin)

6 CONCLUSIONS OF LAW

- 7 1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 8 2. The Board has received substantial evidence supporting the Findings of Fact described
9 above and said findings constitute unprofessional conduct or other grounds for the Board to
10 take disciplinary action.
- 11 3. The conduct and circumstances described above constitute unprofessional conduct
12 pursuant to A.R.S. §32-2501(21)(c)("[p]erforming healthcare tasks that have not been
13 delegated by the supervising physician"); A.R.S. §32-2501(21)(j) ("[a]ny conduct or
14 practice that is or might be harmful or dangerous to the health of a patient or the public");
15 A.R.S. §32-2501(21)(p) ("[f]ailing or refusing to maintain adequate records on a patient.");
16 A.R.S. §32-2501(21)(a) ([v]iolating or attempting to violate, directly or indirectly, or
17 assisting in or abetting the violation of or conspiring to violate a provision of this chapter.
18 A.R.S. §32-2532(A) Except as provided in subsection F of this section, a physician assistant
19 shall not prescribe, dispense or administer: 1. A schedule II or schedule III controlled
20 substance as defined in the federal controlled substances act of 1970 (P.L. 91-513; 84
21 Stat.1242; 21 United States Code section 802) without delegation by the supervising
22 physician, board approval and drug enforcement administration registration. 2. A schedule
23 IV or schedule V controlled substance as defined in the federal controlled substances act of
24 1970 without drug enforcement administration registration and delegation by the supervising
25 physician.")

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2 **ORDER**
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4 Based upon the foregoing Findings of Fact and Conclusions of Law,

5 IT IS HEREBY ORDERED:

- 6 1. Respondent is issued a **Letter of Reprimand**; and
7 2. Respondent is placed on **Probation** for one year with the following terms
8 and conditions:

9 a. Practice Restriction

10 Respondent shall not prescribe, administer or dispense controlled
11 substances until she successfully completes the PACE prescribing course.

12 b. Continuing Medical Education

13 Respondent shall complete the PACE Prescribing Course within six
14 months of the effective date of this Order. The CME hours shall be in
15 addition to the hours required for the annual renewal of licensure. The
16 Probation shall terminate upon successful completion of the coursework.

17 c. Obey All Laws

18 Respondent shall obey all state, federal and local laws, all rules governing
19 the practice of medicine in Arizona, and remain in full compliance with any
20 court ordered criminal probation, payments and other orders.

- 21 3. The Board retains jurisdiction and may initiate new action based upon any
22 violation of this Order.

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1 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

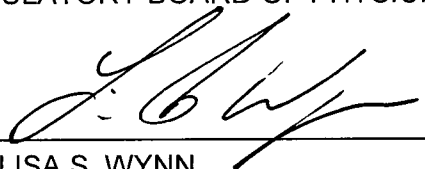
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3 Respondent is hereby notified that she has the right to petition for a rehearing or review. The
4 petition for rehearing or review must be filed with the Board's Executive Director within thirty (30)
5 days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must
6 set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of
7 this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for
8 rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is
9 mailed to Respondent. Respondent is further notified that the filing of a motion for rehearing or
10 review is required to preserve any rights of appeal to the Superior Court.

11 DATED this 24th day of February, 2011.



THE ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS

17 By

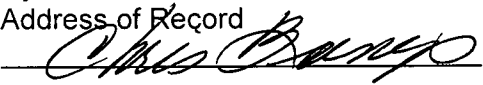

LISA S. WYNN
Executive Director

18 ORIGINAL of the foregoing filed this
24th day of February, 2011, with:

19 Arizona Regulatory Board of Physician Assistants
20 9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

21 Executed copy of the foregoing
22 mailed by U.S mail, this 24th day of February, 2011 to:

23 Cynthia D. Lawrence, PA
24 Address of Record


25 #236920